CORAL DESERT ORTHOPAEDICS Sports Medicine

Coral Desert Orthopaedics

in partnership with Southern Utah Clinic P.C. Your Health, Your Choice.®

Patient Problem Detail

Name: _____ Birth Date: _____
Last First Middle Initial Today's Date: _____

PLEASE ANSWER EVERY QUESTION!!!

1. What is your orthopaedic problem today?
(Shoulder, Hip, Knee, etc.) If finger specify which one
_____ ☐ Left ☐ Right

2. When was the onset of your problem?
___# Days ___# Weeks ___# Months ___# Years
☐ Unknown

3. If your complaint is the result of an accident, how and where did the injury occur?

_____
_____
_____
_____

4. Was the onset of your problem?
☐ Gradual (☐ without injury ☐ after accident or injury)
☐ Sudden (☐ without injury ☐ after accident or injury)

5. How can the current problem be described?
☐ Aching ☐ Burning ☐ Constant ☐ Cramping
☐ Crushing ☐ Deep ☐ Dull ☐ Excruciating
☐ Intermittent ☐ Numb ☐ Pressure ☐ Ripping
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing
☐ Tingling ☐ Other _____

6. On a scale of 1-10 with 10 being the most extreme pain you can imagine, indicate the severity of your pain?
Overall ____ (1-10) Left ____ (1-10) Right ____ (1-10)

7a. Symptoms improve with?
☐ Activity ☐ Heat ☐ Ice/Cold ☐ Medication ☐ Rest

7b. Symptoms worsen with?
☐ Activity ☐ Climbing Stairs ☐ Heat ☐ Ice/Cold
☐ Medication ☐ Rest ☐ Sitting ☐ Walking

8. What additional symptoms are you experiencing? (check all that apply)
☐ Bruising ☐ Chills ☐ Fatigue ☐ Fever ☐ Headaches
☐ Instability ☐ Limited Motion ☐ Loss of Feeling
☐ Numbness ☐ Popping/Snapping/Clicking
☐ Radiation of Pain ☐ Sleep Disturbance ☐ Stiffness
☐ Swelling ☐ Tenderness ☐ Tingling ☐ Weakness
Other_____

9. Pain radiates to?
_____
☐ No radiation of pain

10. What time of day are your symptoms the worst?
☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ Unchanged throughout the day

11. Other treatments you have had for this condition?
☐ Casting ☐ Emergency Room ☐ Physical Therapy
☐ Other Physician Name:_____

12. Indicate any past testing you've had done for this problem.
☐ Bone Scan ☐ CAT/CT Scan ☐ Discogram
☐ EMG ☐ Lab Tests ☐ MRI ☐ Ultrasound ☐ X-Ray
☐ Other:
_____
_____

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Please check any of the symptoms that you are ***currently*** experiencing.

General
- ❑ Fever
- ❑ Night Sweats
- ❑ Chills
- ❑ Feeling Poorly
- ❑ Feeling Tired (Fatigue)
- ❑ Recent Weight Gain
- ❑ Recent Weight Loss
- ❑ Immunological Disorders
- ❑ Pregnancy (are you now or could you be pregnant?)

Eyes/Ears/Nose
- ❑ Vision Problems
- ❑ Seasonal Allergies
- ❑ Sinus Congestion
- ❑ Loss of Hearing

Cardiovascular
- ❑ Chest Pain
- ❑ Heart Problems
- ❑ Irregular Heart Beat

Respiratory
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Asthma: Have you ever been hospitalized for Asthma? ❑ Yes ❑ No
  Date of last hospitalization:_____
- ❑ Pulmonary Disease: Do you use oxygen at night? ❑ Yes ❑ No

Skin
- ❑ Easy Bruising
- ❑ Skin Rash/Lesion
- ❑ Skin infection
- ❑ Skin Cancer

Gastrointestinal
- ❑ Abdominal Pain
- ❑ Digestive Problems
- ❑ Nausea
- ❑ Hepatitis
- ❑ Ulcers

Musculoskeletal
- ❑ Joint Pain
- ❑ Previous Fractures
- ❑ Back Pain

Neurological
- ❑ Headache
- ❑ Dizziness
- ❑ Balance Problems
- ❑ Numbness/Tingling
- ❑ Seizures
- ❑ Tremors
- ❑ Fainting (Syncope)

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Agitation

❑ I am not currently experiencing any of these symptoms.